Effective October 1, 2016

2016 HCPCS CODE ADDITIONS

Bolded Codes
Bolded codes indicate notation of special billing policy.

Audiology
92537, 92538

92537, 92538
A report documenting specific findings that cannot be satisfied with a regular chair is required.

Blood Factor
J7188, J7205

J7188
A *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J7205
Modifiers SA and SB are allowed.

DME
E0465, E0466, E1012

E0465, E0466
- The rental rate is $717.56.
- A *Treatment Authorization Request* (TAR) is required for reimbursement.
- Modifier RR is required.
- Apnea monitors are not separately reimbursable with pressure control, volume control or electrical stimulator supplies.
- Codes E0465 and E0466 are non-taxable.

Claims billed for ventilators must list the model number in the *Additional Claim Information field* (Box 19) of the claim or on an attachment.

Claims billed for back-up ventilators must list the model number in the *Additional Claim Information* field (Box 19) of the claim or on an attachment. Claims must also include the following statement in the *Additional Claim Information* field (Box 19): “This is a back-up ventilator.”

E1012
The purchase price and rental rate are $75.99. Modifiers NU or NURB/RBNU are required for reimbursement. Billing frequency is limited to once every five years. Code E1012 is non-taxable.

Implants

L8607

Laboratory

80081, 81162, 81170, 81218, 81219, 81272, 81273, 81276, 81311, 81314, 81545, 81595, 88350, G0475, G0477 – G0483

80081

Obstetric panel (includes HIV testing) is reimbursable for Presumptive Eligibility (PE) services. Billing frequency is limited to once per month for the same provider.

81162

BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis is a once-in-a-lifetime procedure and requires a *Treatment Authorization Request* (TAR) for reimbursement.

A TAR for code 81162 requires documentation of one or more of the following numbered criteria:

1. An individual from a family member with a known deleterious BRCA mutation; OR
2. Personal history of breast cancer plus one or more of the following:
   - Diagnosed at ≤45 years of age; OR
   - Diagnosed at ≤50 years of age with:
     - An additional breast cancer primary
     - One or more close blood relatives with breast cancer at any age
     - One or more close blood relatives with pancreatic cancer
     - One or more close blood relatives with prostate cancer (Gleason score ≥7)
     - An unknown or limited family history
   - Diagnosed at ≤60 years of age with a triple negative breast cancer
   - Diagnosed at any age with:
     - One or more close blood relatives with breast cancer diagnosed at ≤50 years of age
     - Two or more close blood relatives with breast cancer at any age
     - One or more close blood relatives with invasive ovarian cancer
     - Two or more close blood relatives with pancreatic cancer and/or prostate cancer (Gleason score ≥7) at any age
     - A close male blood relative with breast cancer
     - For an individual of ethnicity associated with higher mutation frequency (for example, Ashkenazi Jewish), no additional family history may be required
3. Personal history of invasive ovarian cancer
4. Personal history of male breast cancer
5. Personal history of prostate cancer (Gleason score ≥7) at any age with one or more close blood relatives with breast cancer (≤50 years of age) and/or invasive ovarian and/or pancreatic or prostate cancer (Gleason score ≥7) at any age

6. Personal history of pancreatic cancer at any age with one or more close blood relative with breast cancer (≤50 years of age) and/or invasive ovarian and/or pancreatic cancer (Gleason score ≥7) at any age
7. Personal history of pancreatic cancer and Ashkenazi Jewish ancestry
8. For an individual without history of breast or ovarian cancer:
    - First- or second-degree blood relative meeting any of the above criteria
    - Third-degree blood relative who has breast cancer and/or invasive ovarian cancer and who has two or more close blood relatives with breast cancer (at least one with breast cancer ≤50 years of age) and/or invasive ovarian cancer

81170
A *Treatment Authorization Request* (TAR) is required for reimbursement. TARs for ABL1 gene analysis, variants in the kinase domain must include documentation that the recipient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy. Billing frequency is limited to once in a lifetime.

81218
One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 – C92.02, C92.40 – C92.42 or C92.50 – C92.52. Billing frequency is limited to once in a lifetime.

81219
One of the following ICD-10-CM diagnosis codes is required on the claim: C92.10 – C92.12, D45, D47.3 or D75.81. Billing frequency is limited to once in a lifetime.

81272
One of the following ICD-10-CM diagnosis codes is required on the claim: C43.70, C92.00 – C92.02, C92.40 – C92.42, C92.50 – C92.52, D03.70 – D03.72 or D48.1. Billing frequency is limited to once in a lifetime.

81273
ICD-10-CM diagnosis code C96.2 is required on the claim. Billing frequency is limited to once in a lifetime.

81276
One of the following ICD-10-CM diagnosis codes is required on the claim: C18.0, C18.2 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5. Billing frequency is limited to once in a lifetime.

81311
One of the following ICD-10-CM diagnosis codes is required on the claim: C18.0, C18.2 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5. Billing frequency is limited to once in a lifetime.

81314
ICD-10-CM diagnosis code D48.1 is required on the claim. Billing frequency is limited to once in a lifetime.

81545
Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result requires a *Treatment Authorization Request* (TAR) and has a once-in-a-lifetime frequency limit.

The following criteria must be documented on the TAR:

- Thyroid nodule that is cytologically indeterminate on fine-needle aspiration
- The diagnostic or treatment strategy will be contingent on test results

81595
Reimbursement for cardiology (heart transplant) mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score is limited to a frequency of once per month and requires documentation on the claim or as an attachment to the claim form of the following nine criteria:

- The recipient is between six months and five years post heart transplant.
- The recipient has no acute signs or symptoms of heart failure.
- The recipient has no history of severe allograft vasculopathy.
- The recipient has no history of recurrent rejection.
- The recipient is currently not receiving ≥20 mg of daily oral prednisone.
- The recipient has not received high dose intravenous (I.V.) corticosteroids (CSs) or myeloablative therapy in the past 21 days.
- The recipient has not received blood products or hematopoietic growth factors in the past 30 days.
- The recipient is not pregnant.
- The recipient is 15 years of age or older.

88350
Billing frequency is limited to four per month. CPT-4 code 88350 may be split-billed with modifier 26 or TC. When billing for both the professional and technical components, a modifier is neither required nor allowed.

G0475
HIV antigen/antibody, combination assay, screening is reimbursable for Presumptive Eligibility (PE) services. Billing frequency is limited to once per month.

G0477
Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, capable of being read by direct optical observation only, includes sample validation when performed, per date of service is reimbursable for Presumptive Eligibility (PE) services. Billing frequency is limited to once per week.

This test is Clinical Laboratory Improvement Amendments (CLIA)-waived when performed with a CLIA-waived test kit. Modifier QW signifies that the CLIA-waived kit was used. This is not a waived test when billed without modifier QW.

G0478 – G0483
Drug test(s), presumptive, any number of drug classes and drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers, including, but not limited to GC/MS and LC/MS are reimbursable for Presumptive Eligibility (PE) services. Billing frequency is limited to once per week.

Medicine

93050, J7297, J7298

93050
CPT-4 code 93050 may be split-billed with modifier 26 or TC. When billing for both the professional and technical components, a modifier is neither required nor allowed.

Modifiers SA and SB are allowed. Billing frequency is limited to four per year for any provider.

J7297
Levonorgestrel-releasing intrauterine contraceptive system, three-year duration is restricted to female recipients only. Modifiers SA and SB are allowed.

J7298
Levonorgestrel-releasing intrauterine contraceptive system, five-year duration is restricted to female recipients only. Modifiers SA and SB are allowed.

PAD

J0202, J0596, J0714, J0875, J1447, J1575, J2407, J3090, J3380, J7313, J7328, J9032, J9039, J9271, J9308, Q9980

J0202
Alemtuzumab is indicated for the treatment of relapsing forms of multiple sclerosis. Because of its safety profile, the use of alemtuzumab should be reserved for patients 18 years of age and older who have had an inadequate response to two or more drugs such as, but not restricted to, interferons and glatiramer or other drugs.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J0596
The recommended dose for ruconest, if the patient's weight is less than 84 kg, is 50 IU per kg of body weight. If the patient's weight is greater than or equal to 84 kg, the recommended dose is 4200 IU.

Modifiers SA and SB are allowed. Billing is restricted to ICD-10-CM diagnosis code D84.1.

J0714, J0875
Reimbursement is restricted to patients 18 years of age and older. Modifiers SA and SB are allowed.

J1447
Tbo-filgrastim is reimbursable when billed with one of the following ICD-10-CM diagnosis codes: D70.1, Z51.11, D70.2 and Z51.89. Reimbursement is restricted to patients 18 years of age and older. Modifiers SA and SB are allowed.

J1575
An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J2407, J3090
Reimbursement is restricted to patients 18 years of age and older. Modifiers SA and SB are allowed.

J3380
Reimbursement is restricted to patients 18 years of age and older. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J7313
Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg is reimbursable when billing for the treatment of diabetic macular edema with Iluvien®. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J7328
Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg is reimbursable for the treatment of osteoarthritis of the knees. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Documentation must include all of the following:

- Painful osteoarthritis of one or both knees
- Inadequate response to conservative nonpharmacologic therapy
- Inadequate response to analgesics (for example, acetaminophen) and non-steroidal anti-inflammatory drugs

Modifiers SA and SB are allowed.

J9032
Belinostat is indicated for the treatment of patients 18 years of age and older with relapsed or refractory peripheral T-cell lymphoma.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J9039
Blinatumomab is indicated for the treatment of patients with Philadelphia chromosome-negative relapsed or refractory B-cell precursor acute lymphoblastic leukemia. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J9271
Pembrolizumab is indicated for the treatment of patients 18 years of age and older with:

- Unresectable or metastatic melanoma
- Metastatic non-small cell lung cancer whose tumors express PD-L1 as determined by an FDA-approved test with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving pembrolizumab.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

J9308
Ramucirumab is indicated for patients 18 years of age and older:

- As a single agent, or in combination with paclitaxel for advanced or metastatic, gastric or gastro-esophageal junction adenocarcinoma with disease progression on or after prior fluoropyrimidine-containing or platinum-containing chemotherapy
- In combination with docetaxel for metastatic non-small cell lung cancer with disease progression on or after platinum-based chemotherapy

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Modifiers SA and SB are allowed.

Q9980
Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg is reimbursable for the treatment of osteoarthritis of the knees. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. Documentation must include all of the following:

- Painful osteoarthritis of one or both knees
- Inadequate response to conservative nonpharmacologic therapy
- Inadequate response to analgesics (for example, acetaminophen) and non-steroidal anti-inflammatory drugs

Claims must be billed "By Report." Modifiers SA and SB are allowed.

Radiology

72081 – 72084, 73501 – 73503, 73521 – 73523, 73551, 73552, 74712, 74713, 77767, 77768, 77770 – 77772, 78265, 78266, C2645, C9458, C9459, G0297, Q9950

72081 – 72084, 73501 – 73503, 73521 – 73523, 73551, 73552, 77767, 77768, 77770 – 77772, 78265, 78266
These codes may be split-billed with modifiers 26 and TC. When billing for both the professional and technical components, a modifier is neither required nor allowed.

74712, 74713
Magnetic resonance imaging, fetal, including placental and maternal pelvic imaging when performed is reimbursable for Presumptive Eligibility (PE) services. An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

CPT-4 codes 74712 and 74713 must be split-billed with modifiers 26 and TC. When billing only for the professional component, use modifier 26. When billing only for the technical component, use modifier TC.

C2645
Claims must be billed "By Report" and must include an invoice with the actual cost of the substance. The report must also include documentation of the dose used, the size used per mm^2 and the size of the tumor.

C9458, C9459
HCPCS codes C9458 and C9459 are not split-billable and must not be billed with any modifier. Reimbursement is limited to one unit (one study dose).

G0297
The United States Preventative Services Task Force (USPSTF) recommends annual screening for lung cancer with low-dose ct scan (LDCT) for lung cancer screening in adults 55 to 80 years of age who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

Screening should be discontinued once a recipient has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

HCPCS code G0297 may be split-billed with modifiers 26 and TC. When billing for both the professional and technical components, a modifier is neither required nor allowed.

A report is required for reimbursement.

Q9950
Claims must be billed "By Report."

Surgery

10035, 10036, 31652 – 31654, 33477, 37252, 37253, 39401, 39402, 43210, **47531 – 47540**, 47541, **47542**, 47543, 47544, 49185, 50430 – 50435, 50606, 50693 – 50695, 50705, 50706, 54437, 54438, 61645, 61650, 61651, 64461 – 64463, **65785**, 69209, **C1822**, G9654

47531 – 47540
Providers should document on the claim form that a different access was used.

47542
Bill CPT-4 code 47542 with modifier 59 with additional dilation only once, regardless of the number of additional ducts dilated.

65785
Implantation of intrasomal corneal ring segments is reimbursable for the reduction or elimination of myopia and astigmatism in patients 21 years of age and older with keratoconus requires a *Treatment Authorization Request* (TAR) documenting the following criteria:

- Progressive deterioration of vision such that the patient is unable to achieve adequate functional vision (at least 20/40 or better) with eyeglasses or contacts
- The patient is unable to perform activities of daily living or occupational functions due to progressive vision deterioration
- Corneal thickness greater than or equal to 450 microns at the proposed incision site
- Central cornea is clear
- Recipient's only alternative is corneal transplant

This procedure is not reimbursable for any indication except keratoconus.

C1822
Claims must be billed "By Report." Providers must submit a copy of the invoice for the generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system for reimbursement.

2016 HCPCS CHANGE CODES

Bolded Codes
Bolded codes indicate notation of special billing policy.

DME

K0017, K0018

K0017, K0018
Detachable, adjustable height armrest, base, replacement only, each and upper portion, replacement only, each are no longer rental items and now require modifiers NU or NURB/RBNU for reimbursement.

Immunization

90658, 90748, 91040

90658, 90748
CPT-4 codes 90658 and 90748 are now Medicare non-covered codes.

91040
Do not report more than once per session.

Laboratory

81275, 81400 – 81404, 81406, 81407, 81408, 81500, 81503, 81506, 81508 – 81512, 81599

81275, 81400, 81404, 81407, 81408, 81500, 81503, 81506, 81508 – 81512, 81599
These codes are now Medicare-covered codes.

81401
The following criteria have been added to the list of *Treatment Authorization Request* (TAR) documentation requirements for molecular pathology procedure, Level 2:

- ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant – The patient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy.
- DEK/NUP214 (t [6; 9])(eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed – The patient has acute myeloid leukemia and the test is intended for the process of risk stratification.

81402
The following criterion has been removed from the list of *Treatment Authorization Request* (TAR) documentation requirements for molecular pathology procedure, Level 3:

- KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) – The patient has clinical features suspicious for, or requires the service as a diagnostic test for mastocytosis.

81403
The following criteria have been removed from the list of *Treatment Authorization Request* (TAR) documentation requirements for molecular pathology procedure, Level 4:

- KRAS (Carcinoma), exon 3, codon 61:
  - The patient has colorectal cancer, and
  - The intention to treat or not to treat with anti-EGFR antibodies (cetuximab or panitumumab) will be contingent on the test results

81406
The following criteria have been added to the list of *Treatment Authorization Request* (TAR) documentation requirements for molecular pathology procedure, Level 7:

- PCSK9 (proprotein convertase subtilisin/kexin type 9) eg, familial hypercholesterolemia), full gene sequence
  - Patient has coronary artery disease (CAD) or has risk factors for CAD.
  - The intention to treat or not to treat with PCSK9 inhibitors will be contingent, at least in part, on the test results.

Medicine

95972, 99500, A9520

95972, 99500, A9520
These codes are now Medicare non-covered codes.

PAD

J7180

J7180
HCPCS code J71890 is now a Medicare non-covered code.

P&O

L1902, L8621

L1902
HCPCS code L1902 is now a Medicare-covered code.

L8621
HCPCS code L8621 is now a Medicare non-covered code.

Radiology

70370, 70371, 71034, 72080, 74210, 74220, 74230, 74240, 74241, 74260, 74270, 74290, 76120, 76496, 77075, 77417, 77789, 78264, 78351

70370, 70371, 71034, 72080, 74210, 74220, 74230, 74240, 74241, 74260, 74270, 74290, 76120, 76496, 77075, 77417, 77789, 78264, 78351
These codes are now Medicare non-covered codes.

2016 HCPCS DELETED CODES

Chemotherapy

Deleted Code	Replacement Code
C9025	J9308
C9026	J3380
C9027	J9271
C9442	J9032
J9010, Q9979	J0202

DME

Deleted Code	Replacement Code
E0450, E0460, E0461, E0463, E0464	E0465, E0466

Medicine

Deleted Code	Replacement Code
92543	93537, 93538
95973	95972

PAD

Deleted Code	Replacement Code
C9443	J0875
C9444	J2407
C9446	J3090
C9449	J9039
C9450	J7313
C9457	Q9950
J1446	J1447
J7302	J7313
Q9975	J7205

Radiology

Deleted Code	Replacement Code
72069, 72090	72081 – 72084
73500	73501
73510	73502, 73503
73520	73522, 73523
73530	73501, 73502, 73503
73540	73501, 73502, 73503, 73551, 73552

Surgery (and anesthesia)

Deleted Code	Replacement Code
50392	50432